QIO Program

BFCC-QIO 12th SOW

Annual Medical Services Review Report

Contract Year 4

(January 1 - December 31, 2022)

Region 1

CT – MA – ME – NH – RI – VT

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Kepro™

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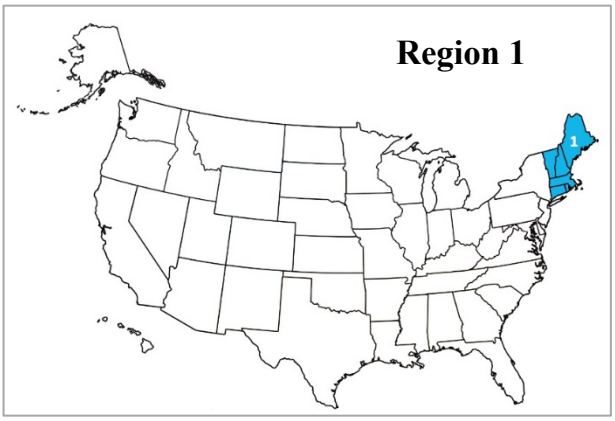
INTRODUCTION:



Kepro is the Centers for Medicare & Medicaid Services (CMS) designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 1, which covers Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The QIO program is an integral part of the U.S. Department of Health and Human Services National Quality Strategy and CMS Quality Strategy. Within this report, you will find data that reflects the work completed by Kepro during the fourth year of its BFCC-QIO contract. The first section of this report contains regional data followed by an Appendix with state-specific data.

The QIO program is all about improving the quality, safety, and value of the care the Medicare beneficiary receives through the Medicare program. CMS identifies the core functions of the QIO program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable, necessary, and provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as: beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

BFCC-QIOs, such as Kepro, review complaints about the quality of medical care. They also provide an appeal process for Medicare beneficiaries when a healthcare provider wants to discontinue services or discharge the beneficiary from the hospital. Kepro provides a service called Immediate Advocacy for beneficiaries who want to quickly resolve a Medicare situation with a provider that does not require a medical record review. By providing these services, the rights of Medicare beneficiaries are protected while also protecting the Medicare Trust Fund.

ANNUAL REPORT BODY:

1) TOTAL NUMBER OF REVIEWS

The data below reflects the total number of medical record reviews completed for Region 1.

The BFCC-QIO has review authority for a number of different situations. These include:

- Beneficiaries or their appointed representatives who have concerns related to the quality of provided healthcare services by either a facility or physician.
- Beneficiaries or their representatives who are appealing a pending hospital discharge or the discontinuation of skilled services such as physical therapy.
- Potential EMTALA violations – In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for an examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability or the patient requests it, an appropriate transfer should be implemented.

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	115	0.66%
Quality of Care Review (All Other Selection Reasons)	123	0.70%
Notice of Non-coverage (Admission and Preadmission, HINN 1)	107	0.61%
Notice of Non-coverage (BIPA)	2,618	14.94%
Notice of Non-coverage (Grijalva)	11,948	68.17%
Notice of Non-coverage (Weichardt)	2,607	14.87%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	8	0.05%
EMTALA 5-Day	1	0.01%
EMTALA 60-Day	0	0.00%
Total	**17,527**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	23,965	23.56%
2. U071 – COVID-19	17,891	17.59%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	10,688	10.51%
4. I110 – Hypertensive Heart Disease with Heart Failure	9,959	9.79%
5. N179 – Acute Kidney Failure, Unspecified	8,366	8.23%
6. J189 – Pneumonia, Unspecified Organism	7,594	7.47%

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
7. N390 – Urinary Tract Infection, Site Not Specified	6,946	6.83%
8. I214 – Non-ST Elevation Myocardial Infarction (NSTEMI)	6,690	6.58%
9. J690 – Pneumonitis Due to Inhalation of Food and Vomit	5,049	4.96%
10. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	4,565	4.49%
Total	**101,713**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	143	13.86%
1: Distinct Psychiatric Facility	9	0.87%
2: Distinct Rehabilitation Facility	12	1.16%
3: Distinct Skilled Nursing Facility	713	69.09%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of an Inpatient Facility	1	0.10%
8: Independent Based Rural Health Clinic	0	0.00%
9: Provider Based Rural Health Clinic	2	0.19%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	2	0.19%
H: Home Health Agency	50	4.84%
N: Critical Access Hospital	25	2.42%
O: Setting does not fit into any other existing code	2	0.19%
Q: Long-Term Care Facility	12	1.16%
R: Hospice	46	4.46%
S: Psychiatric Unit of an Inpatient Facility	3	0.29%
T: Rehabilitation Unit of an Inpatient Facility	1	0.10%
U: Swing Bed Hospital Designation for Short-Term Care, Long-Term Care, and Rehabilitation Hospitals	3	0.29%
Y: Federally Qualified Health Centers	3	0.29%
Z: Swing Bed Designation for Critical Access Hospitals	5	0.48%
Other	0	0.00%
Total	**1,032**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED AND QUALITY IMPROVEMENT INITIATIVES

The below data reflects the category of Quality of Care concerns identified during medical record reviews along with the corresponding outcome.

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care

review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

4A. QUALITY OF CARE CONCERNS CONFIRMED

The below data reflects the total number of confirmed concerns.

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	46	3	6.52%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08], and consultations [see C13 and C14)])	187	10	5.35%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	25	3	12.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	6	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	4	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	5	1	20.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	12	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	13	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	17	1	5.88%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	4	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C15: Apparently did not effectively coordinate across disciplines	3	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	22	6	27.27%
C17: Apparently did not order/follow evidence-based practices	5	1	20.00%
C18: Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	35	7	20.00%
Total	**388**	**33**	**8.51%**

4B. QUALITY IMPROVEMENT INITIATIVES (QIIs)

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up.

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
30	**90.91%**
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	2
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	2
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	2
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	1

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QOC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
30	**90.91%**
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/ adjusting care	1
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	6
Provider-Patient Rights – Improvement needed in other patient rights area	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	4
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	4
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	1

5) DISCHARGE/SERVICE TERMINATIONS

The data below reflects the discharge location of beneficiaries linked to discharge/service termination reviews for Request for BFCC-QIO Concurrence and Weichardt Reviews completed in Region 1. Please note that the discharge location data for the completed appeals reported may be incomplete because of the inability to link them from the claims data.

*Note: Data contained in this table represents discharge/service termination reviews from **January 1, 2022** to **December 31, 2022**.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01: Discharged to home or self-care (routine discharge)	28	12.17%
02: Discharged/transferred to another short-term general hospital for inpatient care	2	0.87%
03: Discharged/transferred to skilled nursing facility (SNF)	102	44.35%
04: Discharged/transferred to intermediate care facility (ICF)	3	1.30%
05: Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06: Discharged/transferred to home under care of organized home health service organization	74	32.17%
07: Left against medical advice or discontinued care	1	0.43%
09: Admitted as an inpatient to this hospital	0	0.00%
20: Expired (or did not recover – Christian Science patient)	2	0.87%
21: Discharged/transferred to court/law enforcement	0	0.00%

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
30: Still a patient	0	0.00%
40: Expired at home (hospice claims only)	0	0.00%
41: Expired in a medical facility (e.g., hospital, SNF, ICF, freestanding hospice)	0	0.00%
42: Expired – place unknown (hospice claims only)	0	0.00%
43: Discharged/transferred to a federal hospital	0	0.00%
50: Hospice – home	3	1.30%
51: Hospice – medical facility	0	0.00%
61: Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed	0	0.00%
62: Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	14	6.09%
63: Discharged/transferred to a long-term care hospital	1	0.43%
64: Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%
65: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66: Discharged/transferred to a critical access hospital	0	0.00%
70: Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
Total	**230**	**100.00%**

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

The data below reflects the number of appeal reviews and the percentage of reviews for each outcome in which the physician reviewer either agreed or disagreed with the hospital discharge or discontinuation of skilled services decision.

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Notice of Non-coverage FFS Preadmission/Admission – (Admission and Preadmission/HINN 1)	107	25.23%	74.77%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/ HINN 10)	8	25.00%	75.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	11,921	39.78%	60.22%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	2,611	29.57%	70.43%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	1,698	8.48%	91.52%

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	905	6.41%	93.59%
Total	**17,250**	**33.30%**	**66.70%**

7) Evidence Used in Decision-Making

The table that follows describes the most common types of evidence or standards of care used to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions for medical necessity/utilization review and appeals.

For the Quality of Care reviews, Kepro has provided one to three of the most utilized types of evidence/ standards of care to support Kepro Review Analysts' assessments, which aid in formatting questions raised to the Peer Reviewer for his/her clinical decisions. A brief statement of the rationale for selecting the specific evidence or standards of care is also included.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
Quality of Care	Pneumonia	CMS' Pneumonia indicators (PN 2-7)	CMS' guidelines for the management of patients with Community Acquired Pneumonia address basic aspects of preventive care and treatment. The guidelines emphasize the importance of vaccination as well as the need for appropriate and timely antimicrobial therapy. Adherence to guidelines is associated with improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Heart Failure	American College of Cardiology (ACC); CMS' Heart Failure indicators (HF 1-3)	ACC's guidelines for the management of patients with heart failure address aspects of care that, when followed, are associated with improved patient outcomes.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org) CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure) UpToDate®	The Agency for Healthcare Research and Quality (AHRQ) remains an excellent online resource for the identification of standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers. CMS' Patient Safety Indicators (PSI) are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Acute Myocardial Infarction	ACC Acute Myocardial Infarction Guidelines; CMS' Acute Myocardial Infarction indicators (AMI 2-10) UpToDate®	ACC's guidelines for the management of patients with an acute myocardial infarction address aspects of care that, when followed, are associated with improved patient outcomes. UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
			decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Urinary Tract Infection	HAI-CAUTI (f/k/a HAC-7)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Sepsis	Institute for Healthcare Improvement (IHI)	IHI developed sepsis indicators and guidelines for the identification and treatment of sepsis. Adherence to such guidelines has improved patient outcomes.
		UpToDate®	UpToDate® is the premier evidence-based clinical decision support resource, trusted worldwide by healthcare practitioners to help them make the right decisions at the point of care. It is proven to change the way clinicians practice medicine and is the only resource of its kind associated with improved outcomes.
	Adverse Drug Events	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/ Standard of Care Selected
	Falls	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Patient Trauma	CMS' Hospital Acquired Conditions & Patient Safety Indicators (PSI-03 & PSI-90 Composite Measure)	CMS' PSIs are measurements of quality of patient care during hospitalization and were developed by AHRQ after years of research and analysis. AHRQ developed the PSIs to help hospitals identify potentially preventable adverse events and serious medical errors.
	Surgical Complications	Surgical complications	Kepro's Generic Quality Screening Tool
Appeals		National Coverage Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria	Determination Guidelines; JIMMO settlement language and guidelines, InterQual®, and CMS' Two Midnight Rule Benchmark criteria Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations are made through an evidence-based process.

8) Reviews by Geographic Area

In tables 8A-B, Kepro has provided the count and percent by rural vs. urban geographical locations for Health Service Providers associated with a completed BFCC-QIO review.

Table 8A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	917	93.86%
Rural	60	6.14%
Unknown	0	0.00%
Total	**977**	**100.00%**

Table 8B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	80	97.56%
Rural	2	2.44%
Unknown	0	0.00%
Total	**82**	**100.00%**

9) Outreach and Collaboration with Beneficiaries

Kepro regularly attends meetings of the Massachusetts Senior Medicare Patrol (MA SMP) Statewide Advisory Committee, which is comprised of diverse representatives who aim to educate Medicare and Medicaid beneficiaries. This valuable partnership with the MA SMP educates Medicare beneficiaries, family members, and professionals on the importance of being engaged healthcare consumers. MA SMP conducted roughly 30 education sessions and has included Kepro's resources, reaching about 10,000 Medicare beneficiaries. Kepro also fosters a relationship with the Massachusetts Long-Term Care Ombudsman Program. Kepro has presented at several state ombudsman meetings with program directors from across the state. The Long-Term Care Ombudsman Program has serviced approximately 15,000 Medicare beneficiaries throughout the state. It also has been a guest on Kepro's "Aging Health Matters" podcast, providing cross-promotional opportunities for both organizations.

10) Immediate Advocacy Cases

The data below reflects the number of beneficiary complaints resolved through the use of Immediate Advocacy.

Based on the nature of the concern(s) raised by the beneficiary, Kepro staff members may recommend the use of Immediate Advocacy. Immediate Advocacy is an informal process used to quickly resolve an oral or verbal complaint. In this process, Kepro makes immediate/direct contact with a provider and/or practitioner for the beneficiary. The Kepro staff member will summarize what Immediate Advocacy involves for the beneficiary and obtain the beneficiary's oral consent to participate in it before proceeding.

During Contract Year 4, Kepro continues to highly encourage Medicare beneficiaries and/or family members to take advantage of Immediate Advocacy benefits. As a result, a high percentage of beneficiary-initiated quality of care complaints are being resolved through its use.

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
676	640	94.67%

11) EXAMPLE/SUCCESS STORY: IMMEDIATE ADVOCACY – 631929

The beneficiary stated she was very upset because she needed mental health assistance but had been on a waiting list for over two years. The care coordinator set up a three-way call with the beneficiary and Lashae, a Medicare representative. After a lengthy hold and conversation, the coordinator helped the beneficiary obtain a list of mental health providers who accepted Medicare and offered telehealth services. The care coordinator contacted the beneficiary to provide the Immediate Advocacy outcome and offer further assistance. She expressed extreme gratitude, stating, "You truly went above and beyond for me. Thank you!" She added no further assistance was required at that time. The coordinator told the beneficiary how to contact Kepro if she had any further questions or concerns.

12) BENEFICIARY HELPLINE STATISTICS

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	67,714
Total Number of Calls Answered	64,949
Total Number of Abandoned Calls	2,419
Average Length of Call Wait Times	00:01:15
Number of Calls Transferred by 1-800-Medicare	47

CONCLUSION:

Kepro's outcomes and findings for Contract Year 4 of this CMS contract outline the daily work performed during the pursuit of care improvements provided to the individual Medicare beneficiary. These reviews provide solid data that can be extrapolated to improve the quality of provider care throughout the system based upon these individual's experiences as a part of the overall system. The Public Health Emergency continued to present unique challenges throughout the year, but Kepro was able to adapt to the circumstances and assist Medicare beneficiaries, their families, and healthcare providers and practitioners.

APPENDIX

KEPRO BFCC-QIO REGION 1 – STATE OF CONNECTICUT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	35	0.45%
Quality of Care Review (All Other Selection Reasons)	31	0.40%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	9	0.12%
Notice of Non-coverage (BIPA)	1,095	14.12%
Notice of Non-coverage (Grijalva)	6,043	77.94%
Notice of Non-coverage (Weichardt)	537	6.93%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.03%
EMTALA 5-Day	1	0.01%
EMTALA 60-Day	0	0.00%
Total	**7,753**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	5,936	27.68%
2. U071 – COVID-19	3,458	16.12%
3. I110 – Hypertensive Heart Disease with Heart Failure	2,074	9.67%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	2,063	9.62%
5. N179 – Acute Kidney Failure, Unspecified	1,939	9.04%
6. N390 – Urinary Tract Infection, Site Not Specified	1,356	6.32%
7. J189 – Pneumonia, Unspecified Organism	1,276	5.95%
8. A4189 – Other Specified Sepsis	1,198	5.59%
9. I214 – Non-ST Elevation Myocardial Infarction	1,105	5.15%
10. J690 – Pneumonitis Due to Inhalation of Food and Vomit	1,043	4.86%
Total	**21,448**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	3,768	62.56%
Male	2,255	37.44%
Unknown	0	0.00%
Total	**6,023**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	54	0.90%
Black	613	10.18%
Hispanic	52	0.86%
North American Native	4	0.07%
Other	55	0.91%
Unknown	90	1.49%
White	5,155	85.59%
Total	**6,023**	**100.00%**
Age		
Under 65	395	6.56%
65-70	694	11.52%
71-80	1,834	30.45%
81-90	2,093	34.75%
91+	1,007	16.72%
Total	**6,023**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	29	11.20%
1: Distinct Psychiatric Facility	2	0.77%
2: Distinct Rehabilitation Facility	2	0.77%
3: Distinct Skilled Nursing Facility	194	74.90%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	1	0.39%
H: Home Health Agency	20	7.72%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	1	0.39%
Q: Long-Term Care Facility	2	0.77%
R: Hospice	8	3.09%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**259**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	6	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis that prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08] and consultations [see C13 and C14)])	57	2	3.51%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	12	2	16.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	2	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	7	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	6	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	6	1	16.67%
C17: Apparently did not order/follow evidence-based practices	3	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	9	1	11.11%
Total	**109**	**6**	**5.50%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
4	**66.67%**
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner ordering necessary laboratory and imaging tests	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	9	0.12%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	2	0.03%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	6,035	78.65%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	1,092	14.23%

Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	315	4.11%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	220	2.87%
Total	**7,673**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	244	98.79%	93.86%
Rural	3	1.21%	6.14%
Unknown	0	0.00%	0.00%
Total	**247**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	21	95.45%	97.56%
Rural	1	4.55%	2.44%
Unknown	0	0.00%	0.00%
Total	**22**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
205	195	95.12%

KEPRO BFCC-QIO REGION 1 – STATE OF MAINE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	9	0.78%
Quality of Care Review (All Other Selection Reasons)	8	0.70%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	12	1.05%
Notice of Non-coverage (BIPA)	89	7.75%
Notice of Non-coverage (Grijalva)	687	59.84%
Notice of Non-coverage (Weichardt)	343	29.88%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**1,148**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,791	24.86%
2. U071 – COVID-19	1,199	16.65%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	751	10.43%
4. I214 – Non-ST Elevation Myocardial Infarction	748	10.38%
5. I110 – Hypertensive Heart Disease with Heart Failure	577	8.01%
6. J189 – Pneumonia, Unspecified Organism	577	8.01%
7. N179 – Acute Kidney Failure, Unspecified	481	6.68%
8. N390 – Urinary Tract Infection, Site Not Specified	397	5.51%
9. R5381 – Other Malaise	341	4.73%
10. J9601 – Acute Respiratory Failure with Hypoxia	341	4.73%
Total	**7,203**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	596	59.30%
Male	409	40.70%
Unknown	0	0.00%
Total	**1,005**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	1	0.10%
Black	2	0.20%
Hispanic	1	0.10%
North American Native	0	0.00%
Other	5	0.50%
Unknown	12	1.19%
White	984	97.91%
Total	**1,005**	**100.00%**
Age		
Under 65	108	10.75%
65-70	127	12.64%
71-80	319	31.74%
81-90	345	34.33%
91+	106	10.55%
Total	**1,005**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	19	17.43%
1: Distinct Psychiatric Facility	2	1.83%
2: Distinct Rehabilitation Facility	1	0.92%
3: Distinct Skilled Nursing Facility	62	56.88%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	2.75%
N: Critical Access Hospital	10	9.17%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	1	0.92%
R: Hospice	7	6.42%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	1	0.92%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.92%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	2	1.83%
Other	0	0.00%
Total	**109**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	10	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	3	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	1	50.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	1	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	3	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	1	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	2	0	0.00%
Total	**28**	**1**	**3.57%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
1	**100.00%**
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Patient Care by Staff – Improvement needed in staff carrying out plan of care	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	12	1.06%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	684	60.69%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	89	7.90%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	179	15.88%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	163	14.46%
Total	**1,127**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	67	65.69%	93.86%
Rural	35	34.31%	6.14%
Unknown	0	0.00%	0.00%
Total	**102**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	3	75.00%	97.56%
Rural	1	25.00%	2.44%
Unknown	0	0.00%	0.00%
Total	**4**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
41	39	95.12%

KEPRO BFCC-QIO REGION 1 – STATE OF MASSACHUSETTS

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	62	1.36%
Quality of Care Review (All Other Selection Reasons)	52	1.14%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	35	0.77%
Notice of Non-coverage (BIPA)	1,052	23.08%
Notice of Non-coverage (Grijalva)	2,390	52.44%
Notice of Non-coverage (Weichardt)	964	21.15%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	3	0.07%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**4,558**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	12,218	21.97%
2. U071 – COVID-19	10,099	18.16%
3. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	6,074	10.92%
4. I110 – Hypertensive Heart Disease with Heart Failure	5,433	9.77%
5. N179 – Acute Kidney Failure, Unspecified	4,431	7.97%
6. J189 – Pneumonia, Unspecified Organism	4,337	7.80%
7. N390 – Urinary Tract Infection, Site Not Specified	4,033	7.25%
8. I214 – Non-ST Elevation Myocardial Infarction	3,334	6.00%
9. J690 – Pneumonitis Due to Inhalation of Food and Vomit	2,897	5.21%
10. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	2,747	4.94%
Total	**55,603**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,758	62.03%
Male	1,688	37.97%
Unknown	0	0.00%
Total	**4,446**	**100.00%**

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Race		
Asian	34	0.76%
Black	195	4.39%
Hispanic	31	0.70%
North American Native	3	0.07%
Other	44	0.99%
Unknown	64	1.44%
White	4,075	91.66%
Total	**4,446**	**100.00%**
Age		
Under 65	369	8.30%
65-70	482	10.84%
71-80	1,283	28.86%
81-90	1,571	35.34%
91+	741	16.67%
Total	**4,446**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	65	14.94%
1: Distinct Psychiatric Facility	4	0.92%
2: Distinct Rehabilitation Facility	6	1.38%
3: Distinct Skilled Nursing Facility	304	69.89%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	1	0.23%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	19	4.37%
N: Critical Access Hospital	2	0.46%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	9	2.07%
R: Hospice	20	4.60%
S: Psychiatric Unit of an Inpatient Facility	3	0.69%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	0.23%
Y: Federally Qualified Health Centers	1	0.23%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**435**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed quality of care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	25	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	94	6	6.38%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	8	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	1	33.33%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	8	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	1	0	0.00%
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	3	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	11	4	36.36%
C17: Apparently did not order/follow evidence-based practices	2	1	50.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	20	5	25.00%
Total	**194**	**17**	**8.76%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
17	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Provider-Continuity of Care – Improvement needed in case management/discharge planning	1
Provider-Continuity of Care – Improvement needed in medical record documentation that impacts patient care	1
Provider-Continuity of Care – Improvement needed in practitioner specialty consultant assessment completion/reporting	2
Provider-Patient Care by Staff – Improvement needed in staff monitoring/reporting of patient changes and response to care/adjusting care	1
Provider-Patient Rights – Improvement needed in notice of noncoverage issuance	6
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of decubiti or worsening of existing decubiti	2
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1

Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of medication errors	1

6) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	35	0.79%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	3	0.07%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	2,384	53.74%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	1,050	23.67%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	714	16.10%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	250	5.64%
Total	**4,436**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	404	99.75%	93.86%
Rural	1	0.25%	6.14%
Unknown	0	0.00%	0.00%
Total	**405**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	42	100.00%	97.56%
Rural	0	0.00%	2.44%
Unknown	0	0.00%	0.00%
Total	**42**	**100.00%**	**100.00%**

8) IMMEDIATE ADVOCACY CASES

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
320	299	93.44%

KEPRO BFCC-QIO REGION 1– STATE OF NEW HAMPSHIRE

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	5	0.42%
Quality of Care Review (All Other Selection Reasons)	10	0.83%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	27	2.25%
Notice of Non-coverage (BIPA)	130	10.85%
Notice of Non-coverage (Grijalva)	710	59.27%
Notice of Non-coverage (Weichardt)	314	26.21%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	2	0.17%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**1,198**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	2,221	22.83%
2. U071 – COVID-19	1,568	16.12%
3. I110 – Hypertensive Heart Disease with Heart Failure	978	10.05%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	968	9.95%
5. I214 – Non-ST Elevation Myocardial Infarction	871	8.95%
6. N179 – Acute Kidney Failure, Unspecified	864	8.88%
7. J189 – Pneumonia, Unspecified Organism	799	8.21%
8. N390 – Urinary Tract Infection, Site Not Specified	645	6.63%
9. I350 – Nonrheumatic Aortic (Valve) Stenosis	408	4.19%
10. I480 – Paroxysmal Atrial Fibrillation	407	4.18%
Total	**9,729**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	675	62.10%
Male	412	37.90%
Unknown	0	0.00%
Total	**1,087**	**100.00%**
Race		
Asian	4	0.37%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Black	13	1.20%
Hispanic	2	0.18%
North American Native	0	0.00%
Other	6	0.55%
Unknown	16	1.47%
White	1,046	96.23%
Total	**1,087**	**100.00%**
Age		
Under 65	124	11.41%
65-70	136	12.51%
71-80	334	30.73%
81-90	356	32.75%
91+	137	12.60%
Total	**1,087**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	14	15.38%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	2	2.20%
3: Distinct Skilled Nursing Facility	55	60.44%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	1	1.10%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	2	2.20%
N: Critical Access Hospital	7	7.69%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	7	7.69%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	1	1.10%
Y: Federally Qualified Health Centers	1	1.10%
Z: Swing Bed Designation for Critical Access Hospitals	1	1.10%
Other	0	0.00%
Total	**91**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	2	50.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08] and consultations [see C13 and C1])	9	1	11.11%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	2	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	1	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	1	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	4	1	25.00%
Total	**24**	**4**	**16.67%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
3	75.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner diagnosis and evaluation of patients	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner general treatment planning/administration	1
Provider-Patient Rights – Improvement needed in other patient rights area	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	27	2.29%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	2	0.17%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	708	59.95%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	130	11.01%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	228	19.31%

MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	86	7.28%
Total	**1,181**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	83	95.40%	93.86%
Rural	4	4.60%	6.14%
Unknown	0	0.00%	0.00%
Total	**87**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural:

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	5	100.00%	97.56%
Rural	0	0.00%	2.44%
Unknown	0	0.00%	0.00%
Total	**5**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
65	63	96.92%

KEPRO BFCC-QIO REGION 1 – STATE OF RHODE ISLAND

1) Total Number of Reviews

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	3	0.13%
Quality of Care Review (All Other Selection Reasons)	11	0.49%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	13	0.58%
Notice of Non-coverage (BIPA)	181	8.07%
Notice of Non-coverage (Grijalva)	1,706	76.02%
Notice of Non-coverage (Weichardt)	330	14.71%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	0	0.00%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**2,244**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	1,053	21.75%
2. U071 – COVID-19	882	18.22%
3. I110 – Hypertensive Heart Disease with Heart Failure	581	12.00%
4. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	563	11.63%
5. I214 – Non-ST Elevation Myocardial Infarction	357	7.37%
6. N179 – Acute Kidney Failure, Unspecified	343	7.08%
7. J189 – Pneumonia, Unspecified Organism	292	6.03%
8. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	262	5.41%
9. J690 – Pneumonitis Due to Inhalation of Food and Vomit	258	5.33%
10. N390 – Urinary Tract Infection, Site Not Specified	251	5.18%
Total	**4,842**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	1,164	62.65%
Male	694	37.35%
Unknown	0	0.00%
Total	**1,858**	**100.00%**
Race		
Asian	2	0.11%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Black	60	3.23%
Hispanic	18	0.97%
North American Native	1	0.05%
Other	24	1.29%
Unknown	19	1.02%
White	1,734	93.33%
Total	**1,858**	**100.00%**
Age		
Under 65	144	7.75%
65-70	208	11.19%
71-80	554	29.82%
81-90	659	35.47%
91+	293	15.77%
Total	**1,858**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	8	9.20%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	1	1.15%
3: Distinct Skilled Nursing Facility	70	80.46%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	5	5.75%
N: Critical Access Hospital	0	0.00%
O: Setting does not fit into any other existing setting code	0	0.00%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	3	3.45%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**87**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	1	1	100.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	11	1	9.09%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	2	1	50.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	**17**	**3**	**17.65%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
3	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner acting on laboratory and imaging test results	1
Practitioner-Patient Care by Practitioner – Improvement needed in practitioner medical record documentation that impacts patient care	1
Provider-Safety of the Environment in Patient Care – Improvement needed in prevention of falls	1

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	13	0.58%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	0	0.00%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	1,702	76.49%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	181	8.13%

Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	159	7.15%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	170	7.64%
Total	**2,225**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	87	100.00%	93.86%
Rural	0	0.00%	6.14%
Unknown	0	0.00%	0.00%
Total	**87**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	4	100.00%	97.56%
Rural	0	0.00%	2.44%
Unknown	0	0.00%	0.00%
Total	**4**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
34	34	100.00%

KEPRO BFCC-QIO REGION 1 – STATE OF VERMONT

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Quality of Care Review (Beneficiary Complaint)	1	0.16%
Quality of Care Review (All Other Selection Reasons)	11	1.76%
Utilization/Medical Necessity (All Selection Reasons)	0	0.00%
Notice of Non-coverage (Admission and Preadmission/HINN 1)	11	1.76%
Notice of Non-coverage (BIPA)	71	11.34%
Notice of Non-coverage (Grijalva)	412	65.81%
Notice of Non-coverage (Weichardt)	119	19.01%
Notice of Non-coverage (Request for QIO Concurrence/HINN 10)	1	0.16%
EMTALA 5-Day	0	0.00%
EMTALA 60-Day	0	0.00%
Total	**626**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, Unspecified Organism	817	20.94%
2. U071 – COVID-19	708	18.15%
3. I214 – Non-ST Elevation Myocardial Infarction	372	9.54%
4. I110 – Hypertensive Heart Disease with Heart Failure	349	8.95%
5. I130 – Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1-4/Unspecified Chronic Kidney Disease	329	8.43%
6. N179 – Acute Kidney Failure, Unspecified	324	8.31%
7. J189 – Pneumonia, Unspecified Organism	324	8.31%
8. N390 – Urinary Tract Infection, Site Not Specified	270	6.92%
9. J441 – Chronic Obstructive Pulmonary Disease with Acute Exacerbation	227	5.82%
10. I480 – Paroxysmal Atrial Fibrillation	181	4.64%
Total	**3,901**	**100.00%**

3) BENEFICIARY DEMOGRAPHICS POSSIBLE DATA SOURCE

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	299	57.95%
Male	217	42.05%
Unknown	0	0.00%
Total	**516**	**100.00%**
Race		
Asian	0	0.00%

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Black	3	0.58%
Hispanic	1	0.19%
North American Native	0	0.00%
Other	6	1.16%
Unknown	8	1.55%
White	498	96.51%
Total	**516**	**100.00%**
Age		
Under 65	36	6.98%
65-70	67	12.98%
71-80	174	33.72%
81-90	174	33.72%
91+	65	12.60%
Total	**516**	**100.00%**

4) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	8	15.69%
1: Distinct Psychiatric Facility	1	1.96%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	28	54.90%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent Based Rural Health Clinic (RHC)	0	0.00%
9: Provider Based Rural Health Clinic (RHC)	1	1.96%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	1	1.96%
H: Home Health Agency	1	1.96%
N: Critical Access Hospital	6	11.76%
O: Setting does not fit into any other existing setting code	1	1.96%
Q: Long-Term Care Facility	0	0.00%
R: Hospice	1	1.96%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	1	1.96%
Z: Swing Bed Designation for Critical Access Hospitals	2	3.92%
Other	0	0.00%
Total	**51**	**100.00%**

5) Quality of Care Concerns Confirmed and Quality Improvement Initiatives

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and Congress.

Kepro, in keeping with CMS directions, has referred all confirmed Quality of Care concerns that appear to be systemic in nature and appropriate for quality improvement activities to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related to documentation, Kepro retains them and works directly with the healthcare provider and/or practitioner.

5A. QUALITY OF CARE CONCERNS CONFIRMED

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care (excludes laboratory and/or imaging [see C06 or C09], procedures [see C07 or C08] and consultations [see C13 and C14)])	13	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	1	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultation	0	0	0.00%

Quality of Care ("C" Category) PRAF Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	1	1	100.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	1	1	100.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	**16**	**2**	**12.50%**

5B. QUALITY IMPROVEMENT INITIATIVES (QII)

Quality of Care Concerns Referred for Quality Improvement Initiatives	
Number of Confirmed QoC Concerns Referred for QII	**Percent (%) of Confirmed QoC Concerns Referred for QII**
2	100.00%
Category and Type Assigned to QIIs	**Number of QIIs referred to a QIN-QIO for each Category Type**
Provider-Safety of the Environment in Patient Care 3 – Improvement needed in prevention of falls	2

6) BENEFICIARY APPEALS OF PROVIDER DISCHARGE/SERVICE TERMINATIONS AND DENIALS OF HOSPITAL ADMISSIONS OUTCOMES BY NOTIFICATION TYPE

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Notice of Non-coverage FFS Preadmission/Admission Notice – (Admission and Preadmission/HINN 1)	11	1.81%
Notice of Non-coverage Request for BFCC-QIO Concurrence – (Request for BFCC-QIO Concurrence/HINN 10)	1	0.16%
MA Appeal Review (CORF, HHA, SNF) – (Grijalva)	408	67.11%
FFS Expedited Appeal (CORF, HHA, Hospice, SNF) – (BIPA)	69	11.35%
Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (FFS Weichardt)	103	16.94%
MA Notice of Non-coverage Hospital Discharge Notice – Attending Physician Concurs – (MA Weichardt)	16	2.63%
Total	**608**	**100.00%**

7) Reviews by Geographic Area – Urban and Rural

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	32	65.31%	93.86%
Rural	17	34.69%	6.14%
Unknown	0	0.00%	0.00%
Total	**49**	**100.00%**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State	Percent of Providers in Service Area
Urban	5	100.00%	97.56%
Rural	0	0.00%	2.44%
Unknown	0	0.00%	0.00%
Total	**5**	**100.00%**	**100.00%**

8) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
11	10	90.91%

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